



RESEARCH REPORT

Measuring Progress in Connecting Criminal Justice to Health

A How-to Guide to Performance Management for Practitioners

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Introduction to the CCJH Initiative and Performance Management

This report provides performance management strategies and hands-on guidance for practitioner agencies on how to measure the implementation and ongoing performance of initiatives that enroll people in Medicaid health coverage upon release from incarceration and subsequently connect them with needed health care and medications in the community. Incarcerated people have disproportionately high rates of chronic medical conditions, mental illness, and substance use disorders (NCCHC 2002) that complicate their return to society and contribute to a revolving door of release, relapse, and reincarceration (Mallik-Kane and Visser 2008). Connecting criminal justice-involved people with health insurance and appropriate health services in the community could interrupt this cycle, thus improving public safety and decreasing costs. Improvements in physical and behavioral health may lead to better social functioning, less reoffending, and fewer costs from emergency room visits, hospitalizations, and reincarcerations.

The guidance in this report incorporates best practices in performance management with lessons learned from the Connecting Criminal Justice to Health Care (CCJH) initiative. This Bureau of Justice Assistance-sponsored collaboration brought together state and local corrections and health care officials in the State of Maryland and Los Angeles County, California, with national experts at the Urban Institute (Urban) and Manatt Health from May 2016 through February 2017 to develop and implement a range of strategies for connecting justice-involved people with health care. Maryland and Los Angeles County also developed performance measures to monitor and manage their efforts to link people with health coverage and community-based services as they transitioned from incarceration to the community.

This section is an overview of the CCJH initiative and performance management, including a comprehensive menu of potential performance measures. The rest of this guide gives detailed instructions for developing and sustaining a performance management process specific to connecting people involved with the criminal justice system to health coverage and community-based care.

Overview of CCJH Strategies

State and local teams from Maryland and Los Angeles County worked with national experts at Urban and Manatt to develop, test, and implement several innovative strategies to maximize enrollment in health coverage and establish links to comprehensive health care. A companion report describes the full range of policies and practices proposed to better connect justice-involved people to health care services upon release.¹ These policies are summarized below to provide context for the performance measures presented in this report.

- Strategies for linking to coverage
 - » Leverage state and local health care navigators, application assisters, and eligibility workers
 - » Establish a special populations enrollment unit
 - » Engage existing justice agency vendors in enrollment
 - » Train justice-involved peer assisters to support enrollment
 - » Target high-need individuals for enrollment
 - » Establish IT processes for checking Medicaid status to enrolled uninsured people
 - » Establish effective processes for suspension or reclassification
 - » Renew eligibility for incarcerated beneficiaries

- Strategies for establishing systems of comprehensive, coordinated care
 - » Engage Medicaid managed care organizations (MCOs) in care coordination
 - » Automatically assign justice-involve populations into managed care
 - » Establish routine and robust care transition processes
 - » Establish health home or health home-like initiatives
 - » Employ peer supporters to provide targeted care coordination
 - » Release from prison or jail with at least a 30-day supply of prescription medication
 - » Require MCOs provide Medicaid-allowable services for reentry population

The CCJH initiative focused on connecting prison and jail populations with Medicaid and health services upon release. The performance management methods and strategies outlined here, however, also apply to probation, parole, and other criminal justice system efforts to increase enrollment in Medicaid and links to community-based health services.

¹ See Jesse Jannetta, Stan Dorn, Emma Kurs, Travis Reginal, Jeremy Marks, Kinda Serafi, Jocelyn Guyer, and Christopher Cantrell, *Strategies for Connecting Justice-Involved Populations to Health Care Coverage and Care* (Washington, DC: Urban Institute, 2018).

Specific Initiatives Chosen by Maryland and Los Angeles

The State of Maryland, its three partner local jurisdictions (Baltimore, Harford, and Washington Counties), Los Angeles County, and the California state Medicaid agency participated in several learning collaboratives hosted by the Urban and Manatt technical assistance team. After considering a full menu of policy options for better connecting the criminal justice population with Medicaid and community-based health services, the two sites identified specific initiatives to focus on, launched these initiatives, and began developing performance measures to track progress. (Appendix B presents detailed information about their performance management efforts, including draft measures and scorecards.)

Maryland primarily focused on increasing the Medicaid enrollment capacity of its county detention centers by leveraging the availability of state-funded staff in its county health departments. Enrollment workers were identified in each of the three participating county health departments and stationed on site at the detention centers on designated days to help people with Medicaid applications. A secondary focus was improving statewide electronic data exchanges between local detention facilities, the state prison system, and the Medicaid agency to promote timely suspension and reinstatement of Medicaid benefits as individuals transitioned in and out of jails. These improvements would help the state avoid making monthly managed care capitation payments for incarcerated beneficiaries and facilitate reinstating benefits promptly once men and women were released. The Medicaid agency had hoped to locate a single, centralized source of correctional admissions and release data in the state. Upon finding that these data were decentralized, the agency renegotiated data use agreements with each county and state correctional system to move toward daily data exchanges. Maryland's performance measurement activity focused on Medicaid enrollment in the detention centers rather than renegotiation of data agreements. A prototype performance scorecard is shown in appendix B.

Los Angeles chose to build on enrollment efforts in the county's jail system and target high-needs men and women for enrollment and enhanced linking to community services. The Los Angeles County Department of Health Services, which administers jail medical services, leveraged its recent inclusion in the California Whole Person Care (WPC) initiative to meet this goal. WPC is a Medicaid-funded initiative to enroll frequent users of multiple care systems in Medicaid and provide coordinated medical, behavioral health, and social services to improve people's health and usage outcomes.² The jail reentry population is one of five target groups in the WPC initiative. To be eligible, individuals must have

² More information can be found in, "Medi-Cal 2020 Waiver-Whole Person Care (WPC) Pilots Frequently Asked Questions and Answers Revision 6.0 (2/22/17)," <http://www.dhcs.ca.gov/services/Documents/WPCFAQ2-22-17.pdf>.

complex chronic health needs and a recent history of hospitalization and emergency department use. After ascertaining that existing data systems would not allow them to easily identify people meeting the WPC high-needs criteria, Los Angeles' CCJH team revised its jail intake and screening questionnaires. Working with the broader WPC initiative, the CCJH team also drafted performance indicators specifically oriented toward enrollment and care coordination in a reentry context, shown in appendix B. Finally, as part of WPC, Los Angeles began building a new data system, the care management platform, to support its care coordination and performance management needs.

Why Connect Criminal Justice-Involved People to Health Care?

Each year, approximately 9 million people return to the community from jail (Beck 2006) and more than 600,000 people return from state and federal prisons (Carson and Anderson 2016). Many returners do not reintegrate, which carries personal, societal, and cost implications. Over two-thirds of people returning from state prisons are rearrested, and one-half return to prison (Durose, Cooper, and Snyder 2014), where it costs approximately \$90,000 a year to house each person (Warren 2008). Connecting people with health care upon release may help break this cycle.

Incarcerated people have extensive health needs

Incarcerated people have disproportionately high rates of chronic physical and behavioral health conditions (NCCHC 2002) that complicate their return to society and contribute to a revolving door of release, relapse, and reincarceration (Mallik-Kane and Visser 2008). In addition to improving health, connecting criminal justice-involved people with health insurance and health care services upon reentry could interrupt this cycle.

Chronic physical health problems, mental illness, and substance use disorders occur much more often among incarcerated people than in the general population. People in jails and prisons have 4 times the rate of active tuberculosis found in the general population, 9–10 times the rate of Hepatitis C, and 8–9 times the rate of human immunodeficiency virus (HIV) infection (Davis and Pacchiana 2004; Steadman et al. 2009; Karberg and James 2005). People in prison and jail experience serious psychological distress at three to five times the rate of the general population (Bronson et al. 2017). Similarly, drug use and dependence is much more prevalent in prison (58 percent) and jail (66 percent) populations than in the general population (5 percent).

Unmet health needs complicate reentry into the community after incarceration

Prisons and jails are constitutionally required to provide medically necessary care during incarceration. However, people often face disruptions in medical care and treatment upon release that contribute to recidivism, drug use, and poor and costly health outcomes, including a 12-fold increase in the risk of death in the two weeks following release (Binswanger et al. 2007). Research suggests that 1 in 12 people leaving prisons and jails will be hospitalized within 90 days of release (Wang, Wang, and Krumholz 2013). A large, representative survey of people returning from prison in Ohio and Texas

found that, within 10 months of release, one-fifth had been hospitalized and one-third had sought care in emergency rooms (Mallik-Kane and Visser 2008).

Health problems also complicate reintegration into the community, making it harder to maintain employment, find housing, or get family support. There is a particular nexus between behavioral health and reoffending: people returning from prison with mental health conditions and substance abuse problems reporting higher levels of criminal behavior (Mallik-Kane and Visser 2008).

Connecting people to health care in the community may improve outcomes and reduce costs

Postrelease health crises could be prevented with coordinated connections to care, since problems often result from poor management of chronic health conditions. Problems include a lack of community treatment, abrupt changes in medication and treatment plans, and drug relapse. Interrupted care for chronic illness imposes considerable costs in the community and greater costs in corrections if people are reincarcerated (Wakeman, McKinney, and Rich 2009).

Evidence is emerging that connecting justice-involved people to health coverage and care in the community can improve access to behavioral health services (Morrissey, Steadman, et al. 2006), increase health and well-being (Mallik-Kane and Visser 2008), and possibly reduce recidivism. If states and localities can facilitate such links, they will be in a much stronger position to address the substance abuse issues, chronic mental illness, employment instability, and homelessness that result in many justice-involved people cycling in and out of jails and hospitals.

Medicaid health coverage was a key focus in the CCJH project because nearly all adult citizens with incomes below 138 percent of the federal poverty level are eligible, in states that participate in Medicaid expansion under the Affordable Care Act. Benefits are either terminated or suspended during incarceration, but federal policy encourages reinstatement of Medicaid benefits upon release from prison or jail (CMS 2016).

What Is Performance Management, and Why Does It Matter?

Before discussing the specifics of how to measure efforts to connect criminal justice with health, let's review what performance management means and how it can be helpful. **Performance management** is an ongoing process of examining data to identify how well programs are meeting their goals and facilitate discussion about how to deliver services most effectively and efficiently. Using regularly collected data, stakeholders can monitor programs to learn if they have been implemented as intended and troubleshoot any issues as they arise. The benefits of performance management include

- monitoring program implementation's fidelity to the intended approach,

- informing midcourse corrections,
- obtaining regular feedback on program performance,
- measuring and recognizing success by comparing outcomes to preset targets,
- motivating staff,
- demonstrating program outcomes,
- using program resources effectively and efficiently, and
- justifying requested resources (Rossman and Winterfield 2009).

Performance Management Is a Process

It's helpful to think of performance management as part of a process of continuous quality improvement. Data are important, but performance management isn't just about collecting and reporting data. Rather, it's about using data as a springboard for discussion and action about program goals and operations. Ultimately, performance management is about improving services to clients. At a high level, the process involves

- selecting the programs to focus on and identifying appropriate performance measures;
- collecting and reporting summary data (measures or metrics) about the program;
- holding regularly scheduled "How are we doing?" meetings with staff and partners to review the data, recognize success, and seek explanations for both successes and challenges; and
- feeding the knowledge gained from the performance reports and these meetings into improved program operations.

About the Terminology Used in This Report

We use the **performance management** to encompass the overall process of continuous program improvement using data about program activity and outcomes to help track progress over time; this includes generating the data *and* interpreting the data, seeking reasons for performance, and feeding that back into program operations term. **Performance measures** or **performance indicators** are the specific data points used in this process. Those two terms (measures and indicators) are sometimes used interchangeably.

Performance management is not the same as **program evaluation**. Though performance management provides regular snapshots of how a program is doing, it doesn't explain the program's outcomes. The program staff and stakeholders must periodically review and interpret the data,

brainstorm reasons for successes and challenges, and feed that knowledge back into program operations. By contrast, program evaluations are more costly, one-time “deep dives” that closely examine program outcomes and the reasons behind those outcomes.

CCJH Performance Measures

Performance measures should reflect the results of key activities or steps in the process of enrolling soon-to-be released people into Medicaid and connecting them with postrelease health services in the community, all leading to improved health. Here are two examples:

- **Successful Medicaid enrollment might include** having an enrollment worker meet with people shortly before release, submitting Medicaid applications, and eligibility review and determination by the Medicaid agency.
- **Connecting people to community-based services might involve** having a pre-release discharge planning meeting with them, providing transitional prescription medication, and referring them to a community health provider.

Each of these activities or steps can be quantified with data, allowing stakeholders to assess whether the process is working as desired. Working with site personnel in Maryland and Los Angeles, we developed a comprehensive list of performance measures (exhibit 1) that practitioner agencies can adapt to fit their circumstances. (Detailed information on how to locate such data and calculate these measures is given in appendix A.) These include measures of the resources devoted to service provision (**inputs**); the amount of work performed or service provided (**outputs**); and the quality and impact of services provided (**outcomes**).

We recommend measuring outcomes beyond the amount of service provided. For example, in addition to documenting the number of people who applied for Medicaid, we encourage comparing the number who applied with the total number of people released to calculate the share of the release population that applied. Outcome measures are better indicators of program success because they put the amount of work done (e.g., applications completed) into a broader context and reflect the achievement of program goals (e.g., providing application assistance to all people leaving prison).

We further recommend collecting both intermediate and end outcomes. Intermediate outcomes—like meeting attendance, timeliness, service quality, and participant satisfaction—provide valuable insight into why programs may be falling short of their goals and spark ideas for improvement. These

measures can be collected through structured observations or participant surveys. End outcomes—like the percentage who applied for Medicaid, the percentage who successfully enrolled, improvements in health status, and declines in arrest rates—reflect broader program goals with short- and long-term time horizons. Exhibit 1 identifies measures to consider for ongoing tracking.

Creating and Using Performance Reports

Performance data should be collected and compared to past performance or predetermined targets, reported, and reviewed regularly to facilitate constructive, solution-oriented discussions of how well a program is being implemented and meeting its goals. We recommend reviewing and discussing performance data monthly or quarterly, as well as when special needs arise during the year.

Consider developing cross-agency performance partnerships to develop and collect performance measures, set performance targets, and participate in ongoing performance management and quality improvement efforts. Connecting recently incarcerated people to health services often requires coordination across criminal justice and health agencies; the numbers, likewise, may need to come from multiple agencies. That said, for most performance measures it is not necessary to link data at an individual level. Aggregate statistics can be used across agencies, as long as the numbers reflect roughly comparable groups of people. A guiding principle is that it's better to be roughly right than precisely ignorant. This report includes high- and low-tech options for creating performance measures across multiple agency data sources.

Performance reports or scorecards can list multiple indicators in a single table (exhibit 10 on page 33) or show a single indicator with detailed breakouts of client characteristics (exhibit 11 on page 34). Additional examples are in appendix B.

Systematic review and discussion of performance reports are key to improving programs. Hold regularly scheduled “How are we doing?” meetings with program staff and stakeholders to review the data, recognize progress, troubleshoot difficulties, and develop action steps as needed. Including program staff in the process fosters accountability and promotes buy-in; staff may be able to identify obstacles and develop solutions that help them do their jobs more effectively. Keep the tone positive to maintain a focus on problem-solving and continuous program improvement.

EXHIBIT 1. CCJH GOALS AND MENU OF POTENTIAL PERFORMANCE MEASURES

Goal: Assess and Manage Medicaid Status on Entry to Jail or Prison

- Number and percentage of individuals admitted to jail who matched to Medicaid database
- Number and percentage of people with Medicaid and other insurance coverage
- Number and percentage of people with Medicaid placed in suspension status within X days of admission
- Average number of days from admission to Medicaid suspension
- Number and percentage of people whose Medicaid was terminated within X days of admission
- Average number of days from admission to Medicaid termination

Goal: Enroll Soon-to-Be Released Individuals into Medicaid

- Number and percentage of people whose Medicaid was reactivated after suspension
- Average number of days between reinstatement and release
- Number and percentage of people who met with outreach staff before release
- Average number of days between outreach and expected release date
- Average number of days between outreach and actual release date
- Staff time spent on Medicaid outreach (hours or equivalent number of full-time employees)
- Number and percentage of Medicaid applications submitted
- Number and percentage of people for whom a Medicaid application was submitted
- Average number of days between application submission and expected release date
- Average number of days between application submission and actual release date
- Client satisfaction with application process (average rating or percentage that rated service above or below a predetermined threshold)
- Quality of enrollment sessions (average rating or percentage that rated service above or below a predetermined threshold)
- Number and percentage of applications approved
- Number and percentage of people for whom a Medicaid application was approved
- Number and percentage of people with active Medicaid status within X days of release
- Number and percentage of applications denied, by denial reason
- Average number of days between application submission and enrollment
- Average number of days between enrollment and release
- Number and percentage of people who chose a primary care physician within X days of enrollment (or within X days of release)
- Number and percentage of people who completed MCO selection within X days of enrollment (or within X days of release)
- Average number of days between enrollment and selection
- Average number of days between selection and release

EXHIBIT 1, CONTINUED

Goal: Provide Corrections-to-Community Transitional Services upon Release

- Number and percentage of people who met with community provider staff before release
- Number and percentage of people for whom an appointment was made with a community provider
- Number and percentage of people who kept their appointment with a community provider
- Amount of staff time spent on discharge planning (e.g., equivalent number of full-time employees)
- Number and percentage of people who received a prescription at release
- Number and percentage of people who received a supply of medication at release
- Number and percentage of people for whom a medical record or care summary was transmitted to a community provider within X months of release

Goal: Provide Health Services in the Community

- Number and percentage of people who visited a community care provider within X months of release (e.g., primary care provider, outpatient clinic, mental health provider, or substance use treatment program)
- Average number of days from release to first receipt of non-emergency care in the community
- Number and percentage of people who visited an emergency room or were hospitalized within X months of release
- Average number of days from release to first emergency room visit or hospitalization
- Number and percentage of people reporting excellent, very good, good, fair, or poor health when asked to describe their overall health
- Average self-reported rating of health
- Number and percentage of people who had two or more visits with the same non-emergency provider within X months of release

Goal: Reduce Subsequent Criminal Justice System Involvement

- Number and percentage of people arrested within X months of release
- Number and percentage of people admitted to jail or prison within X months of release
- Average number of days from release to rearrest
- Average number of days from release to reincarceration

Goal: Provide Community-to-Corrections Care Continuity upon Reincarceration

- Number and percentage of people who received an intake health assessment within X days of admission
 - Average number of days from admission to assessment
 - Number and percentage of people who received health services within X days of admission (e.g., medical care, mental health care, substance use treatment services)
 - Average number of days from admission to first receipt of health services
-

Using This Guide

The procedures described in this guide provide a process for establishing and sustaining a performance management process. The rest of this report details how to define, collect, report on, and respond to performance measures, drawing on the experiences of the two CCJH practitioner sites and best practices in performance management. By collecting and reporting data regularly, program staff, managers, and stakeholders can learn if programs are being implemented as intended and troubleshoot issues as they arise.

We hope that criminal justice, Medicaid, public health, and community-based practitioners will be encouraged to develop and examine performance measures as they manage initiatives to connect justice-involved people with insurance coverage and community-based care. The benefits of performance management include identifying program successes and challenges, improving program operations, using resources more effectively, and demonstrating program needs and impacts. Using the tools provided in this guide, practitioners will be able to develop and sustain a performance management process to manage the implementation and demonstrate the effectiveness of programs designed to link people with health coverage and health services as they leave prisons and jails and return to the community.

Implementing Performance Management: A Step-by-Step Guide

This hands-on guide for practitioners working in public safety, public health, clinical settings, and community-based settings is based on best practices in performance management and the experiences of the participating CCJH sites. (The case studies in appendix B describe the development of performance measures in Maryland and Los Angeles.) It describes how to measure the implementation and ongoing performance of initiatives to enroll people into Medicaid health coverage when they are released from prison or jail, and subsequently connect them with health care and needed medications in the community. Using the procedures described in this guide, readers will have the tools needed to establish and sustain a performance management process.

Below are the key steps in developing performance measures and implementing performance management (exhibit 2). Each is described in detail in the sections to follow. Many steps in this process can be conducted in parallel.

EXHIBIT 2. CHECKLIST OF KEY STEPS IN DEVELOPING A PERFORMANCE MANAGEMENT PROCESS

- Designate a performance management working group to select initiatives, develop measures, and oversee process (page 13)
 - Map how the service is delivered (page 15)
 - Identify potential measures for each step in the process (page 17)
 - Identify potential data sources for each measure (page 20)
 - Focus measurement on outcomes and the right populations (page 21)
 - Set performance targets (page 24)
 - Plan to make comparisons (page 25)
 - Gather performance data (page 26)
 - Design effective performance reports (page 32)
 - Review and use performance data (page 35)
-

Designate a Performance Management Working Group

A performance management working group selects the initiatives to be measured, identifies potential data sources, decides and designs specific performance measures, sets performance targets, launches the initial data gathering, coordinates ongoing reporting, and engages in program improvement. Key strategies for success include the following:

- **Representation from multiple agencies** because of the multidisciplinary nature of Medicaid enrollment and linking to health services. At a minimum, the groups should include members from correctional and Medicaid agencies. Community health organizations and managed care may also be useful partners.
- **Leadership support** to secure staff time and permission to use data.
- **People accustomed to agency data systems** to speak to the strengths, limitations, and proper interpretation of available information. At some point in the process, the group may conduct an inventory of currently available information to assess whether the data are comprehensive enough to support the selected indicators.
- **IT representation** to help facilitate access to needed data. For example, an IT department could create customized data runs.
- **People with the skill to examine and analyze the performance data.** These people would examine each performance report and, summarize and highlight areas likely to need attention.
- **Organizational stability.** Ideally, performance management efforts are launched within a stable organizational structure, not when an organization is in transition.

Tip: Establishing a working group

- **Set up a two-tiered performance management working group.** Create a larger group with wide representation and leadership participation to secure buy-in and advise the effort, and a smaller subcommittee that accomplishes the tasks of the broader group. The smaller subcommittee would then periodically apprise the larger group of its progress and check in with at key decisionmaking points. A core team in Maryland's Medicaid agency spearheaded its performance management efforts, reaching out to state and local criminal justice partners for data about the justice population (see appendix B).
- **Leverage existing performance management efforts.** The working group does not need to start from scratch; it may be able to coordinate with existing performance measurement groups. In Los Angeles, the CCJH initiative incorporated its programmatic and performance management efforts

into a broader Whole Person Care initiative funded by the state Medicaid program to connect high-need frequent users of medical services with coordinated care services (described above and in appendix B).

Common Challenges for Working Groups to Navigate

In identifying and operationalizing performance measures, agencies may work through several common challenges that are addressed throughout this guide, including these seven:

- **Selecting initiatives to measure.** Practitioners may have multiple initiatives to better connect criminal justice populations with care. Both CCJH sites decided to stage their performance management efforts, focusing on Medicaid enrollment before measuring connections to postrelease health services.
- **Logistical challenges of where and how to obtain data** (see “Identify potential data sources for each measure, page 20, and “Gather performance data,” page 26). Bear in mind that the first year of performance management efforts are developmental, with some amount of trial and error as data and reports are developed.
- Interagency collaboration and cross-agency data sharing (see “Getting data from agency records, including across agencies,” page 27). Appendix C includes resources on how to develop interagency memoranda of agreement (MOAs).
- Technological considerations in matching or linking data records (see “Considerations for linking data across criminal justice and health data systems,” page 28).
- Privacy and confidentiality concerns **for the people represented in the data** (see “Considerations for linking data across criminal justice and health data systems,” page 28). However, it is not necessary to link data at an individual level to develop most performance measures (see “Getting data from agency records, including across agencies,” page 27).
- Organizational culture **toward program improvement efforts.** Program staff may view the performance management process as threatening or be concerned about the public availability of performance reports. This guide offers several tips to promote buy-in and conduct productive “How are we doing?” meetings (see “Review and use performance data,” page 35)
- Resources to establish and continually support performance management. Launching a performance management process certainly an initial investment of staff time. However, the

time to produce and distribute performance reports will likely decrease as the process is routinized. Stakeholders may find that the initial start-up is a worthwhile investment to demonstrate program impact.

Define Outcomes and Performance Measures

Once the working group has decided which programs or initiatives to measure, use the following steps to identify, define, and construct performance metrics. We illustrate these steps using a simplified example of enrolling people in Medicaid.

- Map how the service is delivered. An outcome sequence chart to show the results of each major step can be very helpful here.
- Identify potential measures for each step in the process. We recommend a combination of measures that reflect both the implementation *process* and program *outcomes*.
- Identify potential data sources for each measure.
- Specify the target population(s) for the service, then focus performance measurement on those groups.

Map How the Service Is Delivered

Begin by developing a process map of the service being delivered, also known as a logic model or an outcome sequence chart. Use boxes and arrows to outline the steps and decision points in the process. It is also helpful to state the program's objectives and target population. Two sample processes are shown on the next page: one for enrolling individuals in Medicaid (exhibit 3), and one for connecting individuals to health care in the community (exhibit 4).

Exhibit 3. Sample Logic Model for Medicaid Enrollment

Mission statement: Enroll all reentering individuals in health coverage by helping with applications

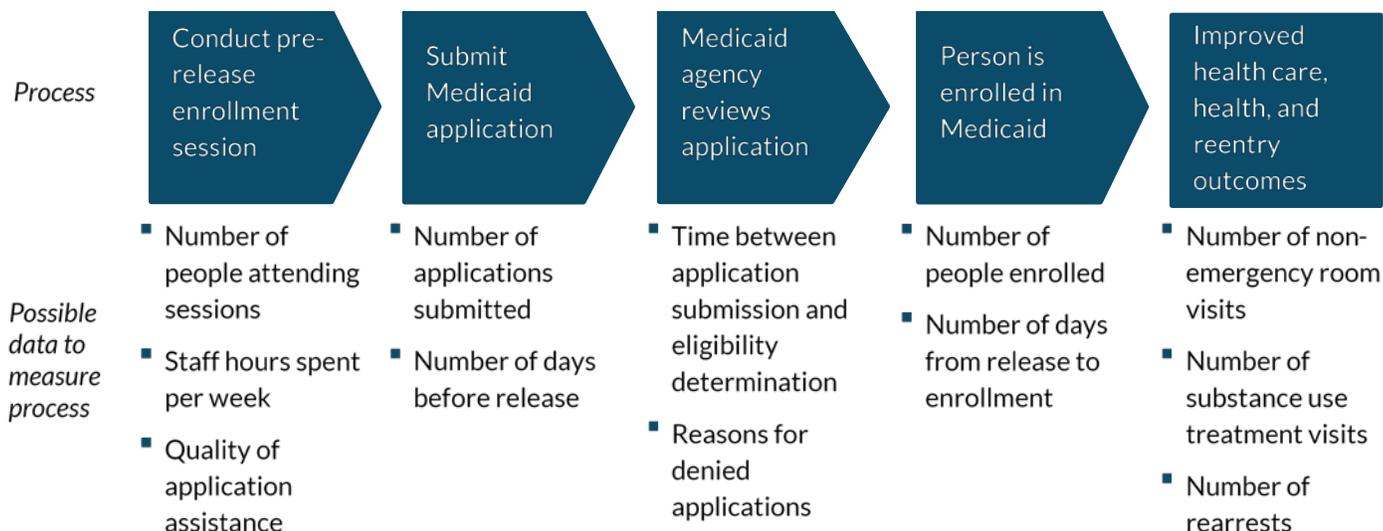
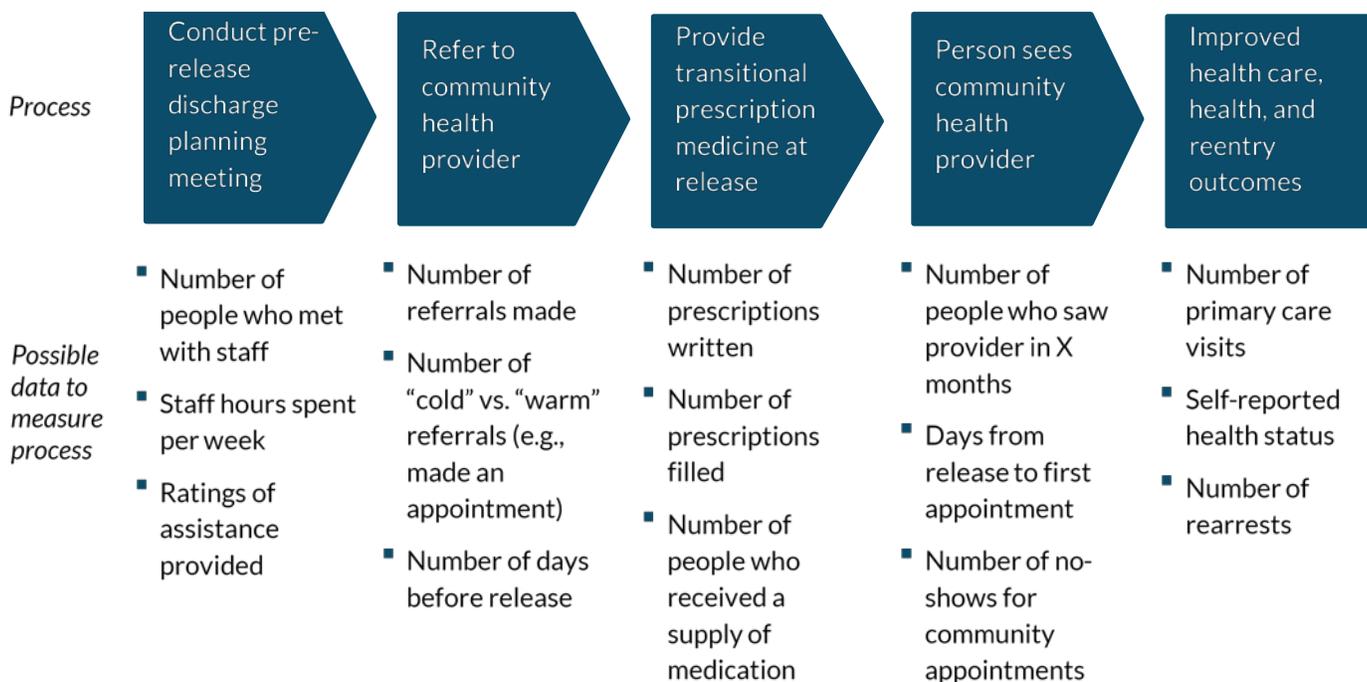


Exhibit 4. Sample Logic Model for Linking to Health Services

Mission statement: Link people receiving correctional health services with care in the community



Identify Potential Measures for Each Step in the Process

After outlining the process, brainstorm potential measures for each step in the process and list them alongside the steps in the process map (exhibits 3 and 4). It's okay for this list to be aspirational; at this stage, the goal is simply to identify what stakeholders would like to know about each step in the process.

Desired measures might be the number and percentage of people helped at each step in the process. Qualitative information, like client satisfaction or reasons for program actions, may further inform some parts of the process. In exhibits 3 and 4, information about client satisfaction and reasons for denying applications would add context for interpreting the number of people enrolled into Medicaid. Information on the timeliness of steps in the process may also help, especially if working group member agencies can adjust the timing of service delivery.

WHY IT'S IMPORTANT TO COLLECT BOTH PROCESS AND OUTCOME MEASURES

Performance measures come in four types (exhibit 5), all of which can be valuable to track. Stakeholders may wish to know the resources that went into service provision (**inputs**), the amount of service provided (**outputs**), the results of the service (**outcomes**), and how well the service was provided (**efficiency**). Generally, input and outputs reflect the program implementation process, while outcome and efficiency measures describe how well the program is achieving its goals. Implementation measures let you know whether the process is being carried out as intended and may highlight parts to troubleshoot. Outcome measures let you know the scale, impact, effectiveness, and efficiency of services. Implementation and outcome measures are both important and informative.

Exhibit 5. Types of Performance Data: Key Definitions

Performance measure type	Example
Input Resources that go into providing a service (e.g., dollars, staff time)	<ul style="list-style-type: none"> ▪ Medicaid enrollment budget ▪ Number of staff hours spent on discharge planning
Output Quantity of work completed or amount of program activity (e.g., number of services provided)	<ul style="list-style-type: none"> ▪ Number of Medicaid applications submitted ▪ Number of people for whom prescriptions were written
Outcome Quality or results of work completed (e.g., client satisfaction, percentage of target population served)	<ul style="list-style-type: none"> ▪ Percentage of people with Medicaid coverage at release ▪ Average days to fill prescriptions ▪ Percentage of people satisfied with help provided ▪ Percentage of people reporting excellent or good health after release
Efficiency Inputs needed to produce outputs or outcomes (e.g., dollars per service, resources used to improve outcome by one unit).	<ul style="list-style-type: none"> ▪ Average dollar cost per application submitted ▪ Median staff time per person successfully enrolled in Medicaid

Programs commonly track their *output*—the amount of services performed, such as the number of people for whom a Medicaid application was submitted. This is certainly important for documenting program activity, like knowing that the program submitted Medicaid applications for 50 people. However, we recommend trying to collect at least some *outcome* measures, as they tend to reflect how well programs are meeting their goals, beyond how much work they are doing (exhibit 6). Outcome measures often put the amount of work done into a broader context and speak to the quality or reach of program services.

Exhibit 6. Output vs. Outcome Measures

Program goal	Output measures (work performed)	Outcome measures (aims achieved)
Medicaid coverage	Number of applications submitted	Percentage of people who applied for Medicaid (within X days of release) or Rating of client satisfaction with the application procedure
Prescription continuity	Number of prescriptions written	Percentage of people for whom prescriptions were written or Percentage of prescriptions filled (within X days of release)
Health care linking	Number of appointments made with community providers	Number and percentage of appointments kept or Average number of days between release and first appointment

Additionally, it can be helpful to track both intermediate and end outcomes. **Intermediate outcomes** reflect steps along the way to the end outcome, like the percentage of people who met with an application worker, or client satisfaction with the application process. Examining intermediate outcomes can help explain why a program is not performing as intended, and inform improvements. For example, a program may find that a very small percentage of people meet with the application worker before release because of timing issues. **End outcomes**, on the other hand, reflect the program’s ultimate goals. For Medicaid application assistance activities, one goal is to ensure that people have health coverage once released from incarceration; a corresponding end outcome measure might be the percentage of jail releasees who had coverage at release. The ultimate goal is for people to receive health services, which would be measured as the percentage that used Medicaid coverage.

Tip: Outcome measures are often (but not always) percentages

Outcome measures are often presented as the percentage of the population to be served: the numerator reflects the amount of work done (e.g., number of applications submitted) and the denominator reflects the universe or target population for that work (e.g., people released from jail). For example, if 50 applications were submitted and 500 people were released from prison that month, the

outcome is an application rate of 10 percent. That same number of applications submitted would reflect a different degree of success if, instead, 100 people were released from prison that month (an application rate of 50 percent). Output measures can be converted to outcome measures by looking at them in relation to the size of the target population. (When you do this, report both numbers and the percentage calculation.) Examples include the percentage of people who meet with outreach staff, the percentage submitting applications, and the percentage covered by Medicaid. That said, remember that not all outcome measures are percentages. Measures of timeliness, service quality, and health outcomes (e.g., a rating score) are important nonpercentage outcomes.

ABOUT UNITS OF COUNT AND UNDUPLICATING DATA

Programs sometimes document their work in the things they did (e.g., number of Medicaid applications submitted); other times, they document work in the number of people served (e.g., number of people for whom they submitted a Medicaid application). Performance measures can be expressed either way, but it is important for stakeholders and reports to be clear about the units being measured. In general, we recommend reporting information about the number of people served. This provides less room for misunderstanding. However, it often is easier for an agency to compile data about the number of services provided.

When counting the number of services performed, working group members should discuss what a service entails and whether it is possible for a given person to receive multiple units of service during the reported period. For example, in the case of Medicaid applications, is it likely that multiple applications would be submitted on behalf of the same person in one month? If someone would receive multiples of a particular service, programs should be careful about how they compute outcome measures. In the case of Medicaid applications, a program might report submitting 100 applications of 200 people released in a particular month. However, this would not necessarily mean 50 percent of people applied unless the program was fairly certain that people did not submit duplicate applications.

Identify Potential Data Sources for Each Measure

As noted earlier, it is okay—important, even—to identify ideal or aspirational measures when developing performance metrics. For each indicator listed in the outcome sequence chart (see exhibits 3 and 4), identify potential data sources *before* determining the feasibility of collecting data. You may find that some desired data don't exist. However, having a list of ideal measures may prompt improvements to current data systems if stakeholders feel that the information to be gained is worth the effort.

Performance measures might come from various data sources, old and new (exhibit 7). A lot of data may already exist in agency records, but sometimes a performance measurement effort will need to generate new data. Ways to collect new data include creating tracking forms to tally program activity; conducting client surveys to obtain feedback on the quality of services; convening focus groups to ask why people don't use services and get suggestions for improvement; and conducting structured observations to assess the environment where services are delivered. Detailed information on each of these data collection methods is presented later (see "Gather performance data," page 26).

Exhibit 7. Potential Sources of Performance Data

Likely existing data sources	Likely new data sources
Agency records	Agency records
Jail or prison management information system	Improvements to existing recordkeeping systems
Correctional health records	New tracking forms used by agency staff
Tracking forms used by agency staff	Clients
Medicaid application and eligibility determination system	Rating forms and surveys
Medicaid claims database	Focus groups
Community-based electronic health records	Trained observer rating procedures
	Structured observation of services provided

The next step is to map program activities, potential indicators, and potential data sources into a single table. Exhibit 8, based on exhibits 3 and 4, lists potential indicators and possible data sources for each indicator.

Exhibit 8. Mapping Selected Program Activities and Outcome Measures to Potential Data Sources (sample)

Activity/Outcome	Data points to measure outcome	Potential data source
Person completes and submits Medicaid application	<ul style="list-style-type: none"> ▪ Number of Medicaid applications submitted ▪ Number of days between application and release ▪ Client satisfaction with application assistance 	<ul style="list-style-type: none"> ▪ Outreach staff member’s log sheets or tracking spreadsheet ▪ Outreach staff calculates day to expected release ▪ Client survey (anonymous rating form in prison)
Correctional medical provider writes prescription for post-release medication	<ul style="list-style-type: none"> ▪ Number of prescriptions written ▪ Number of days between prescription and release 	<ul style="list-style-type: none"> ▪ Correctional health medical chart ▪ Correctional health medical chart

Focus Measurement on Outcomes and the Right Population

So far, the development of performance metrics has focused on output measurements of the amount of work performed (e.g., the number of applications submitted). As discussed earlier, transforming *output* measurements into *outcome* measures brings context to the measures, letting stakeholders know about the scale and impact of the program. Often this means creating a percentage (see the tip on page 24).

Tip: Defining a target population

In designing program services and measuring performance, stakeholders should consider whether to target the full client population or certain specific subgroups. For example, can a correctional institution offer Medicaid application assistance to everyone, or should resources and efforts focus on one subset of the population? Stakeholders may choose to focus on the sentenced population (rather than pretrial detainees) because the greater predictability of their release dates facilitates planning. Or, they might focus on people with the greatest health needs or some other relevant characteristic (such as age). In the CCJH project, Los Angeles chose to focus enrollment efforts on chronically ill frequent service users, as determined by their intake assessment. Maryland kept its enrollment efforts broad but defined its target population as those who had been incarcerated for at least 90 days, corresponding to current practices and the population with an opportunity to receive discharge planning services.

It is possible to measure performance for the whole population *and* for specific subgroups if the relevant data are collected about each person. In this case, stakeholders can consider whether it’s appropriate to assess and report performance for the whole population, specific subgroups, or both. In later sections, we discuss setting differential performance targets (page 24) and reporting subgroup comparisons (exhibit 11, page 34).

To finalize performance indicators, consider whether the data points identified earlier (see exhibit 8) could be transformed into true outcome measures by incorporating appropriate denominators. In

exhibit 9, we suggest potential denominators to focus measurement of outcomes on a particular population. This helps define the population of interest and create a meaningful indicator of the program's reach. For example, instead of simply counting the number of Medicaid applications, a program could divide the number of people for whom an application was submitted by the number of people released to calculate an application rate. Similarly, a program could limit its focus to people with certain health needs; in this case, both the numerator (number of people for whom applications were submitted) and the denominator (number of people) should be restricted to people with the health needs of interest. Note that denominators may not always be applicable or needed. For example, the timeliness of Medicaid application could be reported as the average number of days from application submission to release, which does not need a population denominator.

Exhibit 9. Finalizing Performance Measures as Outcome Measures (sample)

Goal/outcome and performance measure	Data point to measure outcome (numerator)	Potential data sources (for numerator)	Target population options (denominator)
Enroll soon-to-be released people into Medicaid			
Percentage of people who submitted Medicaid applications ^a	Number of Medicaid applications submitted, or (preferably) number of people for whom a Medicaid application was submitted	Outreach staff member's log sheets or tracking spreadsheet	All people released from facility during reporting period, or all releases of a certain legal status (e.g., sentenced), or all releases with certain needs or risk factors
Average time from application to release	Number of days between application and release	Outreach staff calculates day to expected release	Not applicable
Percentage of people rating application assistance as fair or poor	Rating score for client satisfaction with application assistance	Client survey (anonymous rating form used in prison)	Number of clients who participated in survey
Provide transitional prescription medicine			
Percentage of people for whom correctional medical provider writes prescription for post-release medication	Number of prescriptions written	Correctional health medical chart	All people with certain needs or risk factors, or all people released who received medical care during incarceration
Average time from prescription to release	Number of days between prescription and release	Correctional health medical chart	Not applicable

^a Ideally this measure would be calculated using the number of *people* for whom a Medicaid application was submitted divided by the number of people released. However, programs could still look at the number of applications divided by the number of people released; this should be expressed as applications per releasee.

When constructing outcome measures with a numerator and denominator, ensure that both numbers are measuring roughly comparable groups. Sometimes, the way a program is run dictates the

characteristics of the people served. For example, a local jail may only be able to offer help with Medicaid applications to people who were sentenced (because of the difficulty in providing discharge planning services to pretrial detainees.) The number of Medicaid applications submitted thus essentially reflects sentenced people. Ideally, the denominator should similarly exclude pretrial detainees. At the same time, remember that it is better to be roughly right than precisely ignorant.

Connecting People to Care—and Measuring Performance—Differs in Jails and Prisons

Reentry planning involves very different challenges depending on whether a person is in jail or in prison. In most states, jails and prisons serve fundamentally distinct criminal justice functions that translate into very different lengths of stay. Jails are primarily used for pretrial detention, short sentences (typically under one year), and various other needs, such as probation and parole violations and time awaiting transport to prison. Prisons, however, are typically reserved for people who have been convicted and have sentences of one year or longer.

As a result, prisons have longer, more predictable periods to identify needs, conduct programming, and plan for postrelease needs. There is a longer opportunity to assess health needs, activate Medicaid benefits, and make community referrals in time for release. By contrast, jails are characterized by unpredictable release dates and rapid turnover; the exact timing of release often depends on bail and court processes. Some pretrial detainees spend just a few days in jail before they are released on bail or their charges are dismissed. More than half the jail population turns over in a week (Minton and Zheng 2016). Other detainees may remain incarcerated for several months if they cannot afford or are denied bail, or if they are convicted and sentenced to a short term of incarceration. Programming and reentry planning resources are often more limited in jails, and reentry resources must be triaged (Solomon et al. 2008).

The location of jails and prisons add a layer of complexity to reentry planning. Jails are nearer to the communities to which people return, facilitating connection to families and social services. Community health center workers can more easily conduct “in-reach” with potential clients in local jails because short jail stays are less disruptive than prison terms, and jail incarceration is less likely to result in an interruption in public benefits (Morrissey, Dalton, et al. 2006). By contrast, large distances between prisons and the communities to which many people return make collaborative postrelease planning difficult and hamper community-based organizations—including health care providers—from conducting “in-reach” to work with people before release. Despite the closer distance to people’s homes, jail reentry services at the moment of release are limited by the reality that some pretrial detainees are released directly from the courthouse rather than the jail.

Design of an effective reentry interventions—and related performance measures—must take these realities into account. Assistance in a prison could capitalize on the ability to plan for and anticipate the timing of release, but the combination of short stays and unpredictable release dates makes discharge-based planning very challenging in a jail. Efforts to connect people to postrelease care may need to

target specific subgroups of incarcerated people (e.g., by conviction status or geographic location), and these breakouts should be reflected in performance data.

Set Performance Targets

Goal-setting is important to managing programs internally and achieving progress. Comparing performance data with preselected targets will maximize the usefulness of collecting these data.

Stakeholders have several options for choosing performance targets.

- **Past performance.** Track performance over time using performance data from previous months or years for comparison.
- **Service guidelines, regulations, or standards.** Regulations or other practice guidelines may govern how to provide a service. For example, some jurisdictions must meet discharge planning guidelines to maintain compliance with court orders.
- **Research on best practices.** Studies may suggest optimal time frames or caseload sizes for service provision.
- **Available resources.** Targets may change according to the availability of program resources. For example, a working group might reduce its enrollment targets if there are major cuts in the eligibility workforce.

Tip: Setting performance targets by subgroups

Sometimes it's appropriate to set different goals for different client subgroups. For example, a facility may want to enroll 50 percent of its population in Medicaid, but it may set a higher goal for enrolling people with chronic physical or behavioral health needs (e.g., 70 percent) because of the greater importance of connecting those people with services in the community. Similarly, the working group may want to set higher targets for people who received services while incarcerated to promote continuity of care.

Plan to Make Comparisons

Even when a program does not want to target services to any one group, we recommend examining performance across subgroups to identify whether aggregate successes (or challenges) truly reflect the

general experience. Sometimes the experience of one subgroup might mask contrasting experiences in another subgroup.

When planning performance measures, consider which subgroup category comparisons may be important to stakeholders. At the same time, consider which characteristics are available in agency databases. Below is a list of potential breakdowns to consider in tailoring your services to a particular population and/or comparing performance measures across different subgroups.

- **Demographics** (e.g., age, gender, race/ethnicity) to gauge whether different groups are receiving equivalent services
- **Level of health needs** (e.g., chronic physical, mental or addiction problems) to assess how those with the greatest need are served and to compare against subgroups with less severe health problems
- **Service provision** (e.g., received health services, medication in jail) to evaluate continuity of care among those who received services
- **Risk factors** (e.g., homelessness) to examine services for those with complex needs
- **Justice status** (e.g., pretrial or sentenced) since the predictability of people's length of incarceration affects service provision and the ability to plan for release
- **Program locations** (e.g., facilities or wings within the corrections system) to understand geographic variation or service needs among those at different security risk levels

Tip: Finding data on client and service characteristics

Examine available reports and data about the target population to see if specific breakouts are readily available. Consult with people knowledgeable about the underlying data system. Characteristics of interest may be collected and queried though not published. If the information sought is unavailable, consider whether it could be collected moving forward. Los Angeles, for example, added questions to its intake form to better identify its target population (i.e., chronically ill people with recent emergency room visits or hospitalizations).

Gather Performance Data

Assess the availability of the indicators identified earlier (exhibits 8 and 9) and begin collecting the low-hanging fruit. A good strategy can be to begin by collecting the most readily available information and build out from there. Input, output, and target population information are good places to start, such as

- staff time dedicated to the service (e.g., from timekeeping records, the program budget, or a periodic staff survey),
- service counts (e.g., the numbers of sessions held, people served, or applications submitted), or
- existing statistics about the target population (e.g., the number of people released from a correctional facility per month).

Tip: Engaging with the data sooner than later

Identify existing relevant data about the program's target population. This may be easier than collecting performance measures or generating new data, and it provides a base for understanding what information may be available. This exercise would also provide insight on information gaps that may need to be filled.

Over time, programs can collect additional metrics, including client feedback and other outcome measures. In the following sections, we describe how to collect the following:

- **Data from agency records.** These records may have the information needed to develop performance measures. Working group members may find it is useful to combine information across criminal justice and health data systems. Performance measurement needs may also prompt improvements to existing data systems.
- **Feedback from clients.** Agencies may find it helpful to request information from the people released, either at the time of release or a few weeks after release.
- **Insights through program observations.** Structured observations of program operations can also provide information about how effectively services are being implemented.

Getting Data from Agency Records, Including across Agencies

When measuring performance on connecting criminal justice to health, the needed data are likely to come from diverse sources, including different government agencies. Data on Medicaid- or health-

related outcomes might need to come from the health agency, while data on the target population come from the criminal justice agency. The numerator information is usually about Medicaid enrollment or another type of health care outcome, whereas the denominator is about the criminal justice population. What that means for constructing performance measures is

- criminal justice agencies need to collect information on Medicaid and health outcomes, or
- Medicaid and health agencies need to collect criminal justice status information about clients (to differentiate from other Medicaid clients), or
- justice and health agencies need to collaborate on putting together data from their respective agencies.

Criminal justice agencies sometimes collect Medicaid- or health-related information in house. One example is when a jail or prison helps incarcerated people apply for Medicaid coverage. The correctional facility might tally the number of people it helps and use that as the source of information about a Medicaid-related outcome. They would then look at the number of people receiving application assistance in relation to the total number being released from the facility.

Sometimes Medicaid or health agencies can track the criminal justice status of their clients. In such an example, the state Medicaid agency might track the source of applications and have a designated code to distinguish applications from the criminal justice system (e.g., an enroller ID). This would allow the Medicaid agency to count applications according to where people applied. So, if the state Medicaid Agency knew that 100 applications came from the state prison system, they could provide that number for performance management.

There are different ways in which coordinated data collection across agencies could happen, including low- and high-tech options:

- **Aggregate data are used from two separate agencies.** A Medicaid or health agency staff person may provide prerelease Medicaid application assistance within a prison and keep a tally of the number of people assisted. The number assisted by the Medicaid staff is used in relation to data obtained from the prison about the total number of people released to yield measures such as percentage of people released who received Medicaid staff assistance.
- **One agency manually tracks the outcomes occurring in another agency.** Prison staff members help people apply for Medicaid before release, then check the status of each application in the state's Medicaid system (e.g., through an online portal). A staff person could then tally the

status of the applications or record outcomes for each person (e.g., in discharge planning records).

- **One agency electronically obtains client characteristics or outcomes from another agency.** In one variation, a Medicaid or health agency may receive an electronic data feed from the justice system. This information could be used to estimate how many people in the Medicaid program are involved in the criminal justice system or to determine which applications were received from correctional institutions. In another variation, a correctional institution may obtain information about Medicaid or health outcomes through an electronic data feed. Information about each person's Medicaid status would be appended to his or her correctional records.

Considerations for Linking Data across Criminal Justice and Health Data Systems

Program managers and stakeholders may find it useful to link records across criminal justice and health data systems for programmatic reasons (e.g., identifying people in need of coverage or other services). These linked data are likely to yield more precise performance measures.

Linking data between correctional and health agencies raises several technological, privacy, and confidentiality considerations, in addition to the staff effort required.

- **Identifying individuals from one system in the other.** One low-tech option for identifying justice-involved people in Medicaid databases is to assign enroller IDs to those who help criminal justice applicants. This would allow the Medicaid agency to query and report the number of applications processed from the criminal justice system. Maryland, for example, is implementing such IDs to facilitate presumptive Medicaid eligibility for people who leave incarceration without the opportunity to complete a standard Medicaid application.

More complex data-matching strategies are needed to more generally identify common clients. Criminal justice and Medicaid agencies rarely assign common identifiers to people, so agencies often use a combination of names, dates of birth, and Social Security numbers (if available) to match client rosters. Some correctional systems (e.g., Connecticut, Arizona) exchange daily lists of incarcerated people with the state Medicaid agency to facilitate benefits suspension and reinstatement. Performance management efforts could leverage these routine transactions to identify and summarize outcomes.

- **Privacy and confidentiality considerations.** Health and justice data are sensitive, and it is important to follow and/or develop policies and data security measures for protecting the privacy of individuals' information when exchanging it for performance measurement. It may also be necessary to impose time limits on the maintenance of these data. For example, a Medicaid agency that receives DOC data to identify justice-involved clients now has an indicator that someone has a criminal history, regardless of the nature of the incarceration or the outcome of the criminal case (e.g., dismissal of charges). While conviction data are public records, arrest data (e.g., from a jail booking file) may not be. Either way, information about current or past incarceration can be stigmatizing. Additionally, health-related information from Medicaid or community providers is often protected, and any information exchange for creating performance measures must comply with relevant local, state, and federal information privacy regulations.

Getting Feedback and Outcome Information from Recently Incarcerated People

Program participants can provide unique perspectives on the helpfulness and ease of accessing services. Surveying service recipients during or after incarceration (e.g., at a community provider or parole office) lets them share their feelings and concerns. After release, surveys can also gather self-reported outcome information, which may be more straightforward than retrieving information from agency databases. You may choose to survey individuals at a specific point (e.g., after completing a Medicaid application in prison) or repeatedly over time (e.g., once before release and again after release). Outcome data may include (a) respondents' experiences in obtaining health coverage and care, including potentially correctible problems that arose; (b) their health and employment status; and (c) any criminal behavior since release. Looking at the aggregated survey findings in addition to performance data from administrative records yields a comprehensive picture of problem areas and progress.

SUGGESTED SURVEY QUESTIONS

Ask respondents to rate different aspects of the services they received as excellent, good, fair, or poor, or on a scale (e.g., from 1 to 10). Questions can ask them to elaborate on negative responses and give suggestions for improvement. These responses can be quite informative and can stimulate and guide additional efforts to improve. Some sample questions are given below; additionally, you might rotate in questions each reporting period on special, timely topics, on which feedback would be helpful.

- Quality and helpfulness of the interactions with outreach staff, and whether the person was able to easily obtain answers to any questions or concerns
- Problems with preparing and submitting applications for Medicaid
- Clarity and helpfulness of information provided, including whether assistance was available in the individual's primary language
- Problems with Medicaid enrollment and subsequent access to health care, including timeliness of the various steps in accessing health care
- Reasons people don't get or show up to services after release
- Self-reported outcomes, such as housing, employment, health status, and any subsequent criminal activity. For example, self-assessments of health as excellent, very good, good, fair, or poor tend to correlate well with objective assessments of health,³ which may be otherwise unavailable.

SURVEY PROCESS

Setting up the survey process may require some outside assistance (e.g., from a local university) to review procedures and question wording, and to help with the tabulation of results. Also consider working with community-based and advocacy groups to design survey procedures and content to ensure that the process is client-centered and that findings will prove helpful to stakeholders and advocates. Once the survey process is established, surveying can become a routine task. For data quality assurance, ask an outside expert to periodically review the survey process (e.g., once a year).

³ 2013 NCQA National Commercial Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

Tip: Encouraging Participation

- Keep the survey short to reduce burden and maximize the likelihood that people will complete it. Aim for a 40 percent response rate; this is better than many expensive national polls.
 - Make the survey easy to read and understand. Write for a 6th grade reading level because some incarcerated people have limited literacy.⁴ Word processing software often includes an option to determine the reading level of a document.⁵
 - Conduct client surveys anonymously unless there is a need to follow up with particular individuals. This may also increase the likelihood of honest feedback.
 - Consider offering multiple ways to complete the survey, including paper, telephone, smartphone, or on a computer (e.g., either the respondent's or at the parole office).
 - Present the survey as an opportunity to confidentially express any complaints or concerns, and that the results will be used to improve services for others in their situation.
 - Work with advocates or community-based organizations to encourage survey completion and perhaps help administer the survey. Respondents may be more likely to participate if asked by community groups rather than corrections.
 - Emphasize that participation is voluntary. Remember that people have the right to decline taking a survey altogether, and to skip questions that make them uncomfortable. Those wishes should be respected. Lack of participation should not affect the ability to access and receive help and services.
 - Send periodic reminders by phone, text, email, and mail if following up with particular individuals. Collect contact information up-front and consider whether it's possible to get updated information from community supervision agencies (e.g., parole or probation).
-

FOCUS GROUPS

Client feedback can also be gathered through focus groups. A focus group can elicit various perspectives as discussants react to each other's sharing of experiences. Groups of 8 to 12 participants can yield informative and manageable discussions. However, focus group findings will be qualitative and, therefore, cannot be quantified into performance measures or compared over time precisely.

Gaining Insights through Structured Program Observations

Trained observer ratings are another way to understand how clients experience the services being provided. This technique can provide insight on why a program is or isn't performing as expected.

⁴ Ethics guidelines for conducting research among incarcerated individuals, for example, suggest using a sixth-grade reading level. See <https://orra.rutgers.edu/prisoners> and <https://www.ncbi.nlm.nih.gov/books/NBK19885/>, accessed October 20, 2017.

⁵ Microsoft Word, for example, can provide readability statistics when checking spelling and grammar in a document.

Trained volunteers or staff systematically observe the location where services are administered. For example, they could observe the area in a jail where Medicaid enrollments are conducted. Using a predetermined rubric to assign ratings, they can record information about the

- actual hours of operation (e.g., Are services provided when they are supposed to be?)
- physical environment (e.g., How clean, noisy, crowded, or uncomfortable is the space?)
- wait times and duration of service encounters (e.g., How long does it really take?), and
- quality of the encounter (e.g., Do clients appear engaged or bored? Do service providers appear respectful and responsive, or rude and aloof? Do people appear satisfied with the encounter?)

The performance management working group can develop a rubric for structured observations. For example, cleanliness can be rated on a scale of 1 to 4, with 1 representing a dirty environment and 4 representing a very clean environment. The rubric should offer verbal or pictorial guidance to operationalize what each of these levels entails. When observations and ratings are collected systematically at regular intervals, stakeholders can get a snapshot of how the program is operating over time and adjust as needed.

Launch Performance Reporting and Ongoing Performance Management

The working group can now pilot-test reporting performance measures. The working group may also coordinate ongoing reporting after the initial measures are piloted and refined. Ongoing performance management entails distributing performance reports and convening regular “How are we doing?” meetings to review, interpret, and act on the data. Distribution of the performance reports and participation in “How are we doing?” meetings should generally extend well beyond the core performance management working group, or be made publicly available, as the group and agency leadership see fit.

Design Effective Performance Reports

Performance reports should present data in a way that is fully understandable, straightforward, and visually appealing. Clarity and readability are key. Two sample formats are presented below.

Exhibit 10 shows multiple performance measures in one report. Each row represents a different performance measure. The columns show the latest value for the measure, as well as previous values and performance targets (i.e., benchmarks) as a point of comparison. The report can be color-coded to quickly highlight whether the current performance for a given measure falls above or below its target. In this example, the program enrolled a lower share of the population into Medicaid in this reporting period and fell short of its performance target. However, the program made improvements in the share of people who received prescriptions at release and met that performance target.

Exhibit 10. Sample Performance Report: Scorecard with Multiple Measures

Outcome	Number, current period	Total population, current period	Share, current period	Share, previous period	Change	Benchmark/target	Difference between current and benchmark
People who completed and submitted Medicaid application	100	200	50%	70%	20-point decrease	80%	30 points below target
Quality of Medicaid application assistance (% rating as excellent or good)	90	200	45%	25%	20-point increase	50%	5 points below target
People who received a prescription at release	140	200	70%	60%	10-point increase	70%	On target

Exhibit 11 focuses on a single performance measure and provides detailed population breakouts of that indicator. The report title provides a mission statement describing the goal being tracked by this measure. The report provides aggregate data for all released individuals as well as subgroup outcomes by two client characteristics of interest—in this example, gender and number of chronic conditions. As another point of comparison, the report lists the performance target for each subgroup and calculates the difference from the current data to see how well the program achieved its goals. In this example, overall performance was 10 percentage points below the program’s enrollment target, but difficulties with enrolling men masked successes in enrolling women. The report also highlights varying degrees of success in enrolling people with different health statuses. The program was most successful in enrolling people with two or more chronic health conditions. However, because it had set a higher target for these individuals, it still needs to increase enrollment among people with multiple chronic conditions.

Exhibit 11. Sample Performance Report: Detailed Breakouts on a Single Measure

Mission statement: Increase access to postrelease care by applying for Medicaid before release

Outcome measure: Number and percentage of released people who applied for Medicaid before release

	People released this month ^a	Medicaid applications submitted this month ^b	Share that applied for Medicaid	Target for this period	Difference
All	500	200	40%	50%	10% points below target
Gender					
Male	450	160	36%	50%	14% points below target
Female	50	40	80%	50%	30% points above target
Number of chronic conditions					
0	100	20	20%	25%	5% points below target
1	150	30	20%	50%	30% points below target
2+	250	150	60%	75%	15% points below target

^a From the prison's management information system.

^b Number of applications from the Medicaid eligibility determination system, selecting records with application source code="DOC."

Tip: Being roughly right is better than being precisely ignorant

For some measures, the measurement values do not need to be linked at an individual level. Both the individuals covered and the periods covered by the values might not exactly match. It is fine to use aggregate numbers, and it is fine to use information from different sources to populate the different columns, as long as they reflect roughly comparable groups of people and time. For example, the data on the number of people released may come from a prison's management information system, but the number of applications submitted may come from the enrollment staff's records or from the state Medicaid agency. As long as both data points roughly reflect the prison population, it is generally fine to mix and match aggregate data from multiple sources, even different agencies. A good practice is to footnote the information about the data sources and periods covered by each measurement if there are any important differences.

Review and Use Performance Data

Performance reports provide snapshots of how well a program is meeting its goals, but they do not provide reasons or solutions. The data are meant to be a jumping-off point to discuss how well the program is working, identify problem areas, and brainstorm potential solutions. Regularly scheduled “How are we doing?” meetings held shortly after a performance report has been released are important opportunities to review, discuss, and act on the information in the performance report.

However, performance reporting can seem threatening if program staff perceive it as a “report card” that is used negatively against them or made public prematurely. This can be especially true if staff feel they don’t have adequate time or resources to do their jobs. It may help to frame performance data as establishing a baseline from which to measure future program activity and, potentially, justify additional resources. Additionally, we recommend distributing performance reports for private discussion before any public dissemination. This maximizes the use of performance data for problem-solving and program improvement, and not just as a “gotcha” process.

Tip: Holding “How are we doing?” meetings

Before the Meeting

- Schedule the meetings regularly (e.g., monthly or quarterly).
- Design performance reports for maximum understandability. At the same time, consider adding a summary of key takeaway points for those who are uncomfortable with data.
- Distribute the performance report before the meeting.
- Designate a program manager to facilitate these meetings, ideally someone at a higher level who can encourage both accountability *and* a problem-solving focus.

During the Meeting

- Keep the tone positive.
- Acknowledge, praise, discuss, and learn from successes.
- Identify, discuss, and troubleshoot program challenges.
- Seek explanations for successes and challenges.
- Brainstorm program improvements and make an action plan for implementing them.

After the Meeting

- Follow up on the steps required by the meeting’s action plan.

In the sample performance report (exhibit 11, page 34), this program did exceedingly well at enrolling women into Medicaid. Congratulate the team for its success and explore what factors facilitated success in enrolling women. Then look at areas in which performance did not meet targets (e.g., among men and people with one or more chronic conditions). Ask whether this performance was

typical or whether there were extenuating circumstances. Discuss whether it's possible to replicate the factors that lead to success among women. Finally, consider possible service improvements, lay out a plan of action, and follow through on the implementation of program changes.

Key Takeaways

We hope this guide has provided criminal justice, Medicaid, public health, and community-based practitioners with the knowledge and tools to develop a performance management process for tracking efforts to better connect people leaving incarceration with Medicaid coverage and community health services. Collecting and reviewing performance data regularly can increase staff engagement, stimulate program innovation, enhance accountability, and, most important, improve services to clients.

We conclude with the following takeaway points:

- Considerable performance measurement can be done with existing or simple-to-collect measures.
- Engage with the data sooner than later. The effort to generate data may highlight gaps in current services or available information, but that may also lead to improvements.
- Measures do not need to be perfect to be informative. It's better to be roughly right than precisely ignorant.
- Look at both the services provided and the size of the target population. This helps highlight the reach or impact of program activities.
- Performance measurement can help you think more critically at how services are targeted and help focus resources.
- Collaboration between DOC and Medicaid is vital since the population is based in the justice system, but outcomes typically occur in the Medicaid and health care spheres.
- However, it is usually possible to track some important measures unilaterally; for example, a justice agency can measure its own application assistance and discharge planning efforts.
- Ongoing data review, conducted in the spirit of collaborative problem-solving, is important to recognize success, identify roadblocks, and continuously improve programs.

Appendix A. Comprehensive Menu of Connecting Criminal Justice to Health Performance Measures

Appendix Table A.1. Construction of CCJH Performance Measures Listed in Exhibit 1

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<p>Assess and manage Medicaid status on entry to jail or prison</p> <p><i>Assess for existing Medicaid coverage upon entry to jail</i></p>	<ul style="list-style-type: none"> Number admitted to jail who matched to Medicaid database Number with Medicaid and other insurance coverage 	<ul style="list-style-type: none"> Medicaid agency eligibility system Intake questionnaire (self-reports of insurance status) 	<ul style="list-style-type: none"> Number admitted to facility during reporting period Number of a certain legal status (e.g., sentenced) admitted during reporting period Number with certain needs or risk factors admitted during reporting period
<p><i>Medicaid agency suspends existing coverage</i></p>	<ul style="list-style-type: none"> Number with Medicaid placed in suspension status within X days of admission Average days from admission to Medicaid suspension (no denominator needed) 	<ul style="list-style-type: none"> Medicaid agency eligibility system 	<ul style="list-style-type: none"> Number admitted to facility during reporting period Number of a certain legal status (e.g., sentenced) admitted during reporting period Number with certain needs or risk factors admitted during reporting period
<p><i>Medicaid agency terminates existing coverage</i></p>	<ul style="list-style-type: none"> Number whose Medicaid was terminated within X days of admission Average days from admission to Medicaid termination (no denominator needed) 	<ul style="list-style-type: none"> Medicaid agency eligibility system 	<ul style="list-style-type: none"> Number admitted to facility during reporting period Number of a certain legal status (e.g., sentenced) admitted during reporting period Number with certain needs or risk factors admitted during reporting period

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<p>Enroll soon-to-be released individuals into Medicaid</p> <p><i>Medicaid reinstates coverage before release, if suspended at entry</i></p>	<ul style="list-style-type: none"> ▪ Number whose Medicaid was reactivated after suspension ▪ Average days between reinstatement and release (no denominator needed) 	<ul style="list-style-type: none"> ▪ Medicaid agency eligibility system 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period
<p><i>Conduct outreach to enroll people needing Medicaid</i></p>	<ul style="list-style-type: none"> ▪ Number who met with outreach staff before release ▪ Average days between outreach and expected release date (no denominator needed) ▪ Average days between outreach and actual release date (no denominator needed) ▪ Staff time spent on Medicaid outreach (hours or number of FTEs) 	<ul style="list-style-type: none"> ▪ Outreach staff's log sheet or tracking spreadsheet ▪ Discharge planning or case management data system ▪ Timekeeping, human resources, or management records ▪ Staff survey 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) <i>released</i> during reporting period ▪ Number with certain needs or risk factors <i>released</i> during reporting period

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<i>Person and/or outreach staff submits Medicaid application</i>	<ul style="list-style-type: none"> ▪ Number of Medicaid applications submitted ▪ Number of people for whom a Medicaid application was submitted ▪ Average days between application submission and expected release date (no denominator needed) ▪ Average days between application submission and actual release date (no denominator needed) ▪ Client satisfaction with application process (average rating or share who rated service above or below a predetermined level) ▪ Quality of enrollment sessions (average rating or share who rated service above or below a predetermined level) 	<ul style="list-style-type: none"> ▪ Outreach staff's log sheet or tracking spreadsheet ▪ Discharge planning or case management data system ▪ Medicaid eligibility data system ▪ Client surveys or rating forms ▪ Trained observer rating of application sessions 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period ▪ Number who met with outreach staff
<i>Person is enrolled in Medicaid (agency approves application, grants eligibility)</i>	<ul style="list-style-type: none"> ▪ Number of applications approved ▪ Number of people for whom a Medicaid application was approved ▪ Number of people with active Medicaid status within X days of release ▪ Number of applications denied, by reason ▪ Average days between application submission and enrollment (no denominator needed) ▪ Average days between enrollment and release (no denominator needed) 	<ul style="list-style-type: none"> ▪ Medicaid agency eligibility system 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors <i>released</i> during reporting period ▪ Number who met with outreach staff ▪ Number who submitted Medicaid application ▪ Number of Medicaid applications

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<i>Person chooses provider and/or selects Managed Care Organization (MCO)</i>	<ul style="list-style-type: none"> ▪ Number who chose a primary care physician within X days of enrollment (or, within X days of release) ▪ Number who completed MCO selection within X days of enrollment (alternately, within X days of release) ▪ Average days between enrollment and selection (no denominator needed) ▪ Average days between selection and release (no denominator needed) 	<ul style="list-style-type: none"> ▪ Medicaid agency eligibility system 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period ▪ Number who submitted Medicaid application
<p>Provide corrections-to-community transitional services upon release</p> <p><i>Community providers conduct in-reach with incarcerated people</i></p>	<ul style="list-style-type: none"> ▪ Number who met with community provider staff before release 	<ul style="list-style-type: none"> ▪ Staff member's log sheet or tracking spreadsheet ▪ Discharge planning or case management data system 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period
<i>Correctional staff refer person to community health provider</i>	<ul style="list-style-type: none"> ▪ Number for whom an appointment was made with a community provider ▪ Number who kept their appointment with a community provider ▪ Amount of staff time spent on discharge planning (e.g., number of FTEs) 	<ul style="list-style-type: none"> ▪ Staff person's log sheet or tracking spreadsheet ▪ Discharge planning or case management data system ▪ Correctional health records ▪ Community health provider records ▪ Timekeeping, human resources, or management records ▪ Staff survey 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<i>Correctional staff provide prescription medicine upon release</i>	<ul style="list-style-type: none"> ▪ Number who received a prescription at release ▪ Number who received a supply of medication at release 	<ul style="list-style-type: none"> ▪ Staff person's log sheet or tracking spreadsheet ▪ Discharge planning or case management data system ▪ Correctional health records ▪ Community health provider records 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period
<i>Correctional staff provide medical records or care summary to community providers</i>	<ul style="list-style-type: none"> ▪ Number for whom a medical record or care summary was transmitted to a community provider within X months of release 	<ul style="list-style-type: none"> ▪ Correctional health records ▪ Community health provider records 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period
Provide health services in the community			
<i>Person receives non-emergency health care in the community</i>	<ul style="list-style-type: none"> ▪ Number who visited a community care provider within X months of release (e.g., primary care provider, outpatient clinic, mental health provider, or substance use treatment program) ▪ Average days from release to first receipt of non-emergency care in the community (no denominator needed) 	<ul style="list-style-type: none"> ▪ Community health provider records ▪ Medicaid claims utilization records 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period
<i>Person receives acute care in the community</i>	<ul style="list-style-type: none"> ▪ Number who visited an emergency room or were hospitalized within X months of release ▪ Average days from release to first emergency room visit or hospitalization (no denominator needed) 	<ul style="list-style-type: none"> ▪ Community health provider records ▪ Medicaid claims utilization records 	<ul style="list-style-type: none"> ▪ Number released from facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) released during reporting period ▪ Number with certain needs or risk factors released during reporting period

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<i>Client's health status changes over time</i>	<ul style="list-style-type: none"> Number reporting excellent, very good, good, fair or poor health when asked to describe their overall health Average self-reported rating of health (no denominator needed) 	<ul style="list-style-type: none"> Client surveys or rating forms 	<ul style="list-style-type: none"> Number who participated in survey or rated service
<i>Person is engaged in care in the community</i>	<ul style="list-style-type: none"> Number who had two or more visits with the same, non-emergency provider within X months of release 	<ul style="list-style-type: none"> Community health provider records Medicaid claims utilization records 	<ul style="list-style-type: none"> Number released from facility during reporting period Number of a certain legal status (e.g., sentenced) released during reporting period Number with certain needs or risk factors released during reporting period
Reduce criminal justice system involvement <i>Person recidivates</i>	<ul style="list-style-type: none"> Number of people who are arrested within X months of release Number of people admitted to jail or prison within X months of release Average number of days from release to first arrest (no denominator needed) Average number of days from release to first reincarceration (no denominator needed) 	<ul style="list-style-type: none"> Law enforcement records Correctional records 	<ul style="list-style-type: none"> Number of people released from facility during reporting period Number of people of a certain legal status (e.g., sentenced) released during reporting period Number of people with certain needs or risk factors released during reporting period

Goals and program activities	Data points to measure outcome	Potential data sources	Target population (denominator) options*
<p>Provide community-to-corrections care continuity upon reincarceration</p> <p><i>Assess health needs</i></p>	<ul style="list-style-type: none"> ▪ Number who received an intake health assessment within X days of admission ▪ Average days from admission to assessment 	<ul style="list-style-type: none"> ▪ Booking and intake records ▪ Correctional health records 	<ul style="list-style-type: none"> ▪ Number admitted to facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) admitted during reporting period ▪ Number with certain needs or risk factors admitted during reporting period
<p><i>Provide correctional health services</i></p>	<ul style="list-style-type: none"> ▪ Number who received health services within X days of admission (e.g., medical care, mental health care, substance use treatment services) ▪ Average days from admission to first receipt of health services 	<ul style="list-style-type: none"> ▪ Correctional health records 	<ul style="list-style-type: none"> ▪ Number admitted to facility during reporting period ▪ Number of a certain legal status (e.g., sentenced) admitted during reporting period ▪ Number with certain needs or risk factors admitted during reporting period

* Use the target population as the denominator with the outcome indicator to create a percentage measure. Note that target population information typically comes from a corrections or criminal justice data source.

Appendix B. CCJH Case Studies

The two CCJH sites—Maryland and Los Angeles—implemented strategies to increase Medicaid enrollment among their jail populations. This section describes their process for developing performance measures to track the success of those initiatives.

State and Medicaid-Led Effort: Maryland

Maryland is an example of a state- and Medicaid led CCJH initiative, in which the Medicaid agency spearheaded efforts to increase enrollment capacity at county detention facilities and streamline its suspension and reinstatement policies.

Maryland decided to focus its performance measurement on enrollment efforts at its county detention centers. Medicaid-funded staff from the county health departments were stationed in local detention centers to conduct Medicaid enrollment.

Enrollment workers have been tracking the number of applicants assisted pre-release and post-release at local health departments. Additionally, they are tracking the number enrolled and those referred to a navigator.

Further, Urban’s technical assistance team recommended tracking the numbers of people released from each facility to provide a denominator for the enrollment activity. Maryland determined that using the population incarcerated for at least 90 days would be the most appropriate denominator because these are the individuals for whom discharge planning was feasible in the local detention centers. Additionally, the technical assistance team recommended tracking the percentage of each jail’s population that is in pretrial detention (as opposed to sentenced confinement) to provide an indicator of the stability of the jail’s population and its capacity for discharge planning. (Recall that pre-trial populations have highly unpredictable lengths of stay, making it difficult to conduct meaningful discharge planning.) Finally, the technical assistance team recommended documenting each detention facility’s policies and priorities for providing discharge planning to provide further context for enrollment statistics. Exhibit B.1, below, provides a simplified prototype scorecard.

Exhibit B.1. Prototype of Medicaid Enrollment Scorecard

Goal: Enroll soon-to-be and recently released individuals in Medicaid

Period of data = _____

	County/ Facility A	County/ Facility B	County/ Facility C	County/ Facility D
Target population: Number of people released after 90+ day length of stay				
Percent of pretrial detainees in target population				
Number of people enrolled in Medicaid				
Percent of target population enrolled current reporting period				
Percent of target population enrolled last reporting period				
Difference in percentage enrolled between current and last reporting periods				
Note: Screening criteria for meeting with health depart-ment enroller				

Note: Specify data sources for the following columns: target population and number enrolled in Medicaid

One logistical challenge in Maryland has been the necessity of collecting these indicators from each county. In other states, centralized data may be available at the state level (e.g., from a criminal justice coordinating council).

Local and Corrections-Led Effort: Los Angeles, California

Los Angeles is an example of a locally led CCJH initiative that ultimately focused on a particularly high-needs segment of its correctional population. The Los Angeles County's Integrated Jail Health Services, housed within the Department of Health Services (DHS), spearheaded the local CCJH initiative in collaboration with the Los Angeles County Sheriff's Department (LASD), the Los Angeles County Department of Public Social Services (DPSS, the county-level Medicaid agency), the California Department of Health Care Services (CA-DCHS), and many other state and local stakeholders.

While DHS and LASD had a longstanding effort to provide Medicaid enrollment assistance to people incarcerated at the LA County jail, the CCJH team ultimately leveraged other efforts within the county and state to focus on linking a subset of high-need individuals to coverage and care. The team capitalized on Los Angeles' participation in a larger Medicaid Whole Person Care (WPC) project,⁶ which aims to enroll and connect five distinct populations of chronically ill frequent service users with comprehensive, coordinated Medicaid services. The reentry population is one of these five populations; the others are people with serious mental illness, substance use disorder, or complex medical needs, and people experiencing homelessness.

To establish and monitor these efforts, the local CCJH team first needed to develop an operational definition for identifying chronically ill frequent service users in the county jail. While some measures of health status could be gathered from existing LASD and DHS data systems, information on service usage was not readily available (e.g., recent hospitalizations or emergency room use). The team felt self-reports would be more efficient and responsive to current needs than attempting to consolidate information from existing records. The local CCJH team decided to collect new, self-reported measures of health and recent health care usage by adding psychosocial assessment to existing booking and intake procedures. Those who met criteria related to chronic health needs, recent hospitalization or ER use, and elevated socioeconomic needs (e.g., homelessness) were targeted for inclusion in the Medicaid WPC project to connect them with comprehensive, coordinated Medicaid services. WPC-eligible individuals may be uninsured at jail entry or have existing Medicaid coverage. Enrollment into Medicaid is an initial WPC service if needed; the focus is on enhanced care coordination for this high-needs population.

Performance measures focused on services to be provided to these high-need individuals after Medicaid enrollment. Draft performance indicators (exhibit B.2) included a combination incarceration-specific measures and broader measures of health care usage. Notably, some measures pertain to linking to in-jail medical services if and when a WPC client becomes reincarcerated.

⁶ See <http://www.dhcs.ca.gov/provgovpart/Documents/LosAngelesWPCApplication.pdf>, accessed September 21, 2017.

Exhibit B.2. Draft Performance Measures

Medicaid enrollment of target population

- Total number of people entering the jail
- Number and proportion who met eligibility criteria after screening
- Number and proportion who were enrolled into Medicaid and WPC program

Jail-based discharge planning

- Proportion of WPC clients who chose a community provider before release
- Proportion of WPC clients for whom medical records were transmitted to a primary care provider

Community health services

- Proportion of WPC clients who visited a primary care provider within X months of release
- Proportion of WPC clients who visited a mental health provider within X months of release
- Proportion of WPC clients who received substance use treatment services within X months of release
- Proportion of WPC clients with improvement in self-reported health status
- Proportion of WPC clients who maintained linkage to primary care X months post-release
- Number of emergency department visits by WPC clients
- Number of inpatient hospitalizations by WPC clients

Criminal justice outcomes

- Proportion of WPC clients arrested within X months of release from jail
- Proportion of WPC clients reincarcerated within X of release from jail

Care continuity if reincarcerated

- Proportion of incarcerated WPC clients who were assessed by caseworker within X hours of admission to jail
- Proportion of incarcerated WPC clients who were connected to in-jail behavioral health services

Appendix C. Additional Resources

For those seeking additional information, we have compiled these resources on performance management in general, linking health and justice data, and developing interagency memoranda of understanding to facilitate data sharing.

Performance Management

Linda M. Lampkin, and Harry P. Hatry, *Key Steps in Outcome Management* (Washington, DC: Urban Institute, 2003), <https://www.urban.org/research/publication/key-steps-outcome-management>.

Nonprofits are increasingly asked to provide evidence that their programs help clients. Even without such pressure, they should operate and manage their resources in a way that is most effective for clients. Regularly collected feedback on service outcomes can help provide the needed evidence on impacts and create learning organizations that constantly improve their services. This guide is the first in a series designed to help nonprofits that wish to introduce outcome management or improve their use of the process. It documents the key steps in establishing and maintaining an outcome-oriented measurement process and in using the data collected.

Elaine Morley and Linda M. Lampkin, *Using Outcome Information: Making Data Pay Off* (Washington, DC: Urban Institute, 2004), <https://www.urban.org/research/publication/using-outcome-information>.

After investing in identifying and measuring outcomes, analyzing the data, and reporting results to funders, many nonprofits do not take full advantage of their hard work. Nonprofit program managers may use the information, but there are also other important audiences. Some of these are within the organization, for example, board members and direct service personnel, such as service workers and counselors. In addition, there are a number of potential external users. These could include funders, community members, volunteers, clients, and other nonprofit organizations providing similar services. This guide provides ideas on effective uses of outcome information for nonprofits.

Marty Abravanel, *Surveying Clients about Outcomes* (Washington, DC: Urban Institute, 2003), <https://www.urban.org/research/publication/surveying-clients-about-outcomes>.

Surveying clients on a routine basis is one very important method that nonprofit organizations can use to assess service outcomes. Nonprofits do not have to become survey experts, as technical expertise and support are available, but they must understand what surveys involve, recognize good survey practice, and make decisions about the roles played by staff members versus those by survey technicians. The goal is to help ensure that useful data of high quality are collected. This guide provides information on what nonprofits need to know and consider when client surveys are used to track performance.

Morris L. Thigpen, Thomas J. Beauclair, George M. Keiser, and Lori Eville, *Measuring What Matters: Outcome and Performance Measures for the Pretrial Services Field* (Washington, DC: US Department of Justice, National Institute of Corrections, 2011), <https://www.pretrial.org/download/performance-measures/Measuring%20What%20Matters.pdf>.

This monograph presents recommended outcome and performance measures and mission-critical data for pretrial service programs. It is hoped that these suggested measures will enable pretrial service agencies to gauge more accurately their programs' effectiveness in meeting agency and justice system goals. The contributors to this monograph believe the recommended elements are definable and measurable for most pretrial service programs and are consistent with established national pretrial release standards and the mission and goals of individual pretrial programs. The monograph defines each measure and critical data element and identifies the data needed to track them. It also includes recommendations for programs to develop ambitious but reasonable target measures. Finally, the monograph's appendix lists examples of outcome and performance measures from three nationally representative pretrial service programs.

Public Health Foundation, *Performance Management Toolkit* (Washington, DC: Public Health Foundation, n.d.), available at http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/Performance_Management_Toolkit.aspx

Performance management is a systematic process that helps an organization achieve its mission and strategic goals. PHF produces and provides resources and tools, including case stories, white papers, and customized technical assistance, that can help individuals and organizations move from learning to application. The purpose of this toolkit is to help people understand performance management and how to develop successful performance management systems. This toolkit was designed to respond to an organization's needs regardless of where that specific organization is on the road to effective performance management.

Patricia Lichiello, *Turning Point Guidebook for Performance Measurement* (Seattle: University of Washington Turning Point National Program Office, 2010), <http://www.phf.org/resourcestools/Documents/PMCguidebook.pdf>.

The Turning Point Guidebook for Performance Measurement offers the fundamentals of performance measurement in public health. It covers basic information about what we mean by performance measurement in general, and background information on performance measurement in public health, in particular. It offers reasons for developing a performance measurement process and a description of the key components in developing such a process. It offers performance measurement strategies tried by public health practitioners across the country and by other public and private sector organizations.

Public Health Foundation, *From Silos to Systems: Using Performance Management to Improve the Public's Health* (Seattle: University of Washington Turning Point National Program Office, 2010), <http://www.phf.org/resourcestools/Documents/silossystems.pdf>.

This guide was primarily developed to assist state health agency (SHA) leaders in understanding performance management and how its practice can improve an agency's capacity and ability to carry out the 10 Essential Public Health Services. Others that can benefit from reading this guide include: local public health agencies, tribal agencies, territorial agencies, educators, state legislators or other policy makers, public health professional associations, federal agencies that fund or set requirements for states related to performance management, and other public health system partners.

US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), *Performance Management and Measurement* (Washington, DC: HHS, HRSA, 2011), <https://www.hrsa.gov/quality/toolbox/508pdfs/performanceandmeasurement.pdf>.

The purpose of this module is to introduce the fundamental concepts of performance management and assist an organization to develop a practical strategy for achieving its quality

improvement (QI) goals. This module highlights the use of evidence-based performance measures to set QI goals and evaluate an organization's progress in meeting them.

Health and Justice Data Sharing

Scott Parker, Kamala Mallik-Kane, and Aaron Horvath, *Opportunities for Information Sharing to Enhance Health and Public Safety Outcomes: A Report by the Criminal Justice and Health Collaboration Project* (Ashburn, VA: The IJIS Institute, 2013), <http://cdm16064.contentdm.oclc.org/cdm/ref/collection/p266901coll4/id/4195>.

Information sharing between the criminal justice and healthcare communities has the potential to enhance both public safety and health outcomes by reducing redundancies, enhancing continuity of care, and generating efficiencies in both domains. Thirty-four (34) beneficial opportunities for interdomain information exchange were identified by a BJA-sponsored working group of experts from both the health and justice communities. Used judiciously, and with the necessary legal and technical safeguards to protect privacy and confidentiality, bi-directional sharing of health information between community-based care providers and correctional institutions can be used to divert individuals from the criminal justice system (when appropriate), better provide for their health needs while under justice supervision, and prepare for a successful post-release transition to the community. Information from community-based healthcare providers can enhance the ability of corrections officials to appropriately diagnose issues associated with continuity of care and to ensure no gap in service when incarcerated. Likewise, information from the criminal justice community—including risk assessments, correctional health records, correctional treatment history, and court dates—can support health providers in their care of justice-involved clients.

Justice and Health Connect, *The Justice and Health Connect Toolkit* (New York: Justice and Health Connect, n.d.), accessed July 2017, <http://www.jhconnect.org/toolkit>.

The Justice and Health Connect Toolkit provides a framework for planning, implementing and sustaining interagency collaboration between justice and health systems. The toolkit is organized into four modules, describing the steps to setting up information sharing initiatives. While the toolkit is presented in a linear format, we encourage you to explore the different sections as your information sharing initiative evolves and progresses based on your interests and needs. Wherever possible, the toolkit references real-world examples of jurisdictions that have adopted effective approaches to address information sharing challenges, accessible summaries of the research literature, and examples of best practices." The Toolkit includes modules on Governance (e.g., "Establish a Governing Body") and Legal and Ethical Restrictions (e.g., "Federal Privacy Law"; "State Privacy Law").

Marguerite Ro and Eli Kern, "Role of Data in Transforming Health and Human Services" (Seattle: Washington Accountable Communities of Health, 2017), http://www.publichealthsystems.org/sites/default/files/PHS3/72456GPreport_07.pdf.

In King County, WA, there is a broad understanding that health begins where we live, learn, work and play. Because of this, we know we must work differently, if we are to achieve better and more equitable health at lower costs. Multiple sectors, including but not limited to healthcare, behavioral health, managed care organizations, public health, housing, social services, and community-based organizations, are now partnering in a countywide transformation initiative that aimed at creating an accountable and integrated system of health, human services, and community-based prevention.

This transformation requires new levels of coordination and collaboration and a pressing need

for data. Data are needed for planning, monitoring, and evaluation purposes. At the front-end, data is needed to assure that transformation efforts are data-driven and targeted. At the back-end, data is need to measure progress and to assure that desired outcomes are achieved.

Robert L. Trestman and Rob H. Aseltine Jr., “Justice-Involved Health Information: Policy and Practice Advances in Connecticut,” *Perspectives in Health Information Management* (Winter 2014), <http://perspectives.ahima.org/justice-involved-health-information-policy-and-practice-advances-in-connecticut/>.

This article describes the development and implementation of an interagency release of information (ROI) document and process, a voucher program to provide discharge medications at the time of release, and a statewide research-oriented health information network.

MOUs and Intergovernmental Agreements on Health and Justice Data Sharing

Gregory J. Ahern, letter to Honorable Board of Supervisors, subject, “Authorize the Sheriff to Execute a Memorandum of Understanding between Alameda County and California Department of Corrections and Rehabilitation,” December 2, 2010, http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_12_07_10/PUBLIC%20PROTECTION/Regular%20Calendar/Sheriff_MOU_State_Dept_Corrections_Offender_Reentry.pdf.

The Alameda County Sheriff’s Office will establish a formal partnership with CDCR, and will work collectively with other Alameda County governmental agencies ... to increase communication and cooperation to better serve the offender population with reentry needs in Alameda County.

The partnership, as proposed in this MOU, includes the following elements: data and information sharing, coordination with reentry service providers and local stakeholders, pilot innovative programming and service delivery models, and expand resource and program opportunities.

Allegheny County Department of Human Services and Allegheny County Juvenile Probation Office, “Data Sharing and Data Release Agreement” (Pittsburgh: Allegheny County Department of Human Services and Allegheny County Juvenile Probation Office, n.d.), <http://impact.sp2.upenn.edu/fieldctr/wp-content/uploads/2013/05/Allegheny%20County%20Department%20of%20Human%20Services%20And%20Allegheny%20County%20Juvenile%20Probation%20Office%20Data%20Sharing%20and%20Data%20Release%20Agreement.pdf>.

In order to (1) better serve the youth who are the responsibilities of both parties; (2) improve the delivery of services to children and youth of Allegheny County; (3) meet the reporting requirements of the State and Federal Governments; and (4) complete the requirements under the MacArthur Foundation Project, it is agreed that the parties will share information with each other about the children and youth for whom they are individually and mutually responsible.

The agreement includes the specific data points (e.g., date of adjudication, date of discharge, discharge location, service provision, etc.) to be included in a monthly file of ACJPO youth who were under the supervision of ACPJO.

King County Systems Integration Initiative, “Sample Interagency Agreement on Information Sharing” (Seattle: King County Systems Integration Initiative, n.d.), <http://www.txsystemofcare.org/wp-content/uploads/2014/04/King-County-MOU.pdf>.

This Agreement is to support the exchange of information between parties of the agreement in order to give the most coordinated services possible to those children and families involved in

the juvenile justice and child welfare systems... [It will] delineate how the agencies and the courts will work together to facilitate information sharing and to ensure that confidential information is disseminated only to the appropriate persons or agencies as provided by law or otherwise pursuant to a lawfully obtained consent form.

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